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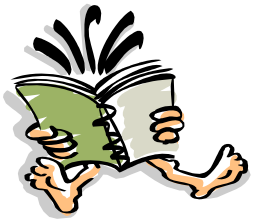
INTRODUCTION

Welcome to the Correct Coding Initiative (CCI) reference guide for Customer Service Representatives (CSRs). This guide is brought to you by the Medicare Learning Network (MLN), the Centers for Medicare & Medicaid Services (CMS) and is designed to provide you with a high level overview of CCI. Upon completion of this program, you will have a solid knowledge base to draw upon when responding to physician and provider inquiries regarding CCI.

WHAT WILL I LEARN FROM THIS GUIDE?

In this guide you will learn:



- What HCPCS codes are
- How physicians and providers submit for reimbursement of services
- What the reasons for incorrect coding are
- What CCI is
- What modifiers are
- What the role of a CSR in CCI is
- What the most frequently asked physician and provider questions are

CHAPTER 1: CODING

In this chapter you will learn:

- What HCPCS codes are
- How physicians and providers submit for reimbursement of services
- Types of incorrect coding

HEALTHCARE COMMMON PROCEDURE CODING SYSTEM

This section provides background information on the Healthcare Common Procedure Coding System (HCPCS) to help CSRs gain a better understanding of the development and use of HCPCS codes.

WHAT ARE HCPCS CODES?

To understand CCI, you must first have a basic understanding of coding. Physicians and providers submit claims for services using a standard code set called the Healthcare Common Procedure Coding System (HCPCS). These codes allow all physicians and providers to code their services similarly. There are over 12,000 HCPCS codes, and approximately 7,000 of these codes describe virtually all physician and provider services such as office visits, surgeries (e.g., removing an appendix, heart bypass surgery, colonoscopy, and repairing a retinal detachment), and immunizations.

The HCPCS system contains two levels of codes. Level I contains the American Medical Association's (AMA) Current Procedural Terminology (CPT) numeric codes. Level II contains alphanumeric codes primarily for items and services not listed in CPT.

More details on HCPCS:

- Level I (CPT) codes are 5-digit numeric codes that describe procedures and services performed by physicians and providers. These codes are copyrighted by the AMA and updated annually.

- Level II are alphanumeric codes that describe items such as drugs, medical equipment, blood products, and temporary procedure or service codes. These codes are maintained by the Centers for Medicare & Medicaid Services (CMS) and updated annually.

CLAIMS SUBMISSION

This section provides CSRs with information regarding how physicians and providers submit for reimbursement of services.

HOW DO PHYSICIANS AND PROVIDERS SUBMIT CLAIMS FOR PAYMENT OF SERVICES?

Physicians and providers submit claims for the services they have provided on a form called the HCFA-1500. Each service a physician or provider performs is submitted on the form as a "line item", which includes the HCPCS code for the service. Although it is common to perform only one service per day for a beneficiary, a physician or provider may provide more than one service to a beneficiary on the same day, which means that the claim could include several "line items".

To demonstrate, consider the following examples:

A. A physician or provider may perform several surgeries during one operative session.

B. A physician or provider may remove a patient's gall bladder, fallopian tubes, appendix, and have to destroy internal scar tissue (called adhesions) during one operation.

INCORRECT CODING

This section provides CSRs with an overview of the types of incorrect coding that can occur.

WHAT ARE SOME TYPES OF INCORRECT CODING?

1) Fragmenting one service into component parts and coding each component part as if it were a separate service.

   Example: The correct CPT comprehensive code to use for upper gastrointestinal endoscopy with biopsy of the stomach is CPT code 43239. Separating the service into two component parts, using CPT code 43235 for upper gastrointestinal endoscopy and CPT code 43600 for biopsy of stomach is inappropriate.

2) Reporting separate codes for related services when one comprehensive code includes all related services.

   Example: Coding a total abdominal hysterectomy with or without removal of tubes, with or without removal of ovaries (CPT code 58150) plus salpingectomy (CPT code 58700) plus oophorectomy (CPT code 58940) rather than using the comprehensive CPT code 58150 for all three related services.

3) Breaking out bilateral procedures when one code is appropriate.

   Example: Bilateral mammography is coded correctly using CPT code 76091 rather than incorrectly submitting CPT code 76090-RT for right mammography and CPT code 76090-LT for left mammography.

4) Down-coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

   Example: A laboratory should bill CPT code 80048, (basic metabolic panel), when coding for a calcium, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, and urea nitrogen performed as automated multi-channel tests. It would be inappropriate to report CPT codes 82310, 82374, 82435, 82565, 82947, 84132, 84295 and/or 84520 in addition to the CPT code 80048 unless one of these laboratory tests was performed at a different time of day to obtain follow-up results, in which case a –91 modifier would be utilized.

5) Separating a surgical approach from a major surgical service.

   Example: A provider should not bill CPT code 49000 for exploratory laparotomy and CPT code 44150 for total abdominal colectomy for the same operation because the exploration of the surgical field is included in the CPT code 44150.

Chapter Notes

CHAPTER 2: CCI BASICS

In this chapter you will learn:

- What NCCI is
- What is the purpose of NCCI
- What is the format for NCCI edits
- What modifiers are
- What the role of the CSR in NCCI is
- What NCCI resources are available

CCI OVERVIEW

This section provides background information on CCI so that CSRs can gain a better understanding of what CCI is, how it came about, and what it is intended to do.

WHAT IS NCCI?

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote correct coding by physicians and providers and to ensure that it made appropriate payments for physician and provider services.

NCCI applies to claims that contain more than one procedure performed on the same beneficiary, on the same date of service, by the same performing provider. The NCCI edits result in denial of claims where one of the services reported on the claim should not have been reported. Additionally,

a. NCCI prevents physicians and providers from reporting two procedures that could not possibly have been performed together.

   Example: reporting the removal of an organ both through an open incision and with laparoscopy.

b. CCI prevents physicians and providers from reporting female and male specific codes for a single patient performed on the same beneficiary, on the same date of service, by the same performing provider.

   Example: reporting a cystourethroscopy, with internal urethrotomy of a female (CPT code 52270) and also of a male (CPT code 52275).

c. NCCI requires physicians and providers to report the complete procedure code instead of reporting multiple codes that describe parts of the complete procedure. In other words it prevents physicians and providers from reporting one or more components of a comprehensive service when a single code is available that describes the complete service.

   Example: a single code describes removal of the uterus, ovaries, and fallopian tubes so physicians and providers should not use separate codes to report, individually, the removal of the uterus, ovaries, and fallopian tubes.

Example: when procedures require that an IV be started in order to perform the procedure, then the physician or provider may not report the code for starting an IV in addition to the code for the procedure.

d. NCCI requires physicians and providers to report only the more extensive version of the procedure performed and disallows reporting of both extensive and limited procedures.

Example: only a deep biopsy should be reported if both a deep and a superficial biopsy is performed at the same location.

Example: a complex repair of a laceration involves several layers of sutures, only a complex repair is reported. Although a simple repair may describe use of a single layer of sutures it is not reported because this layer is included in the complex repair code.

Example: when skin, muscle, and bone are debrided, only the code describing debridement of all these organs is reported. The code describing skin debridement only or skin and muscle debridement only is not reported.

e. NCCI prevents physicians and providers from reporting two procedures together for which there is a third separate code that describes the combination of services.

Example: reporting right heart catheterization (CPT code 93501) and retrograde left heart catheterization (CPT code 93510) when the CPT code 93526 for combined right heart catheterization and retrograde left heart catheterization should be used.

WHAT IS THE FORMAT FOR CCI EDITS?

Each CCI edit consists of a pair of CPT/HCPCS codes that under certain circumstances should not be billed together. These edits are currently listed in two tables. One table is called the correct coding, comprehensive/component table, and the other is called the mutually exclusive table.

This is how the tables appear in the CCI Edits Manual, which is available for purchase from the National Technical Information Service (NTIS).

CORRECT CODING EDITS FOR COMPREHENSIVE CODES 10000-19999

Comprehensive	Component
10021	19290[1]
10022	10021[1], 19290[1]
10040	69990[0]
10060	11055[1], 11056[1], 11057[1], 11719[1], 11720[1], 11721[1], 11730[1], 11740[1], 11765[1], 20500[1], 64400[1], 64402[1], 64405[1], 64408[1], 64410[1], 64412[1], 64413[1], 64415[1], 64417[1], 64418[1], 64420[1], 64421[1], 64425[1], 64430[1], 64435[1], 64445[1], 64450[1], 64475[1], 64479[1], 64483[1], 69990[0], 97601[1], G0127[1]
10061	10060[1], 11055[1], 11056[1], 11057[1], 11719[1], 11720[1], 11721[1], 11730[1], 11740[1], 11750[1], 11760[1], 11765[1], 20500[1], 64400[1], 64402[1], 64405[1], 64408[1], 64410[1], 64412[1], 64413[1], 64415[1], 64417[1], 64418[1], 64420[1], 64421[1], 64425[1], 64430[1], 64435[1], 64445[1], 64450[1], 64475[1], 64479[1], 64483[1], 69990[0], 97601[1], G0127[1]
10080	20500[1], 69990[0]
10081	10080[1], 20500[1], 69990[0]
10120	11055[1], 11056[1], 11057[1], 11719[1], 11720[1], 11721[1], 69990[0], G0127[1]
10121	10120[1], 11720[1], 11721[1], 69990[0]
10140	11055[1], 11056[1], 11057[1], 11719[1], 11720[1], 11721[1], 69990[0], G0127[1]
10160	11055[1], 11056[1], 11057[1], 11719[1], 11720[1], 11721[1], 69990[0], G0127[1]
10180	11720[1], 11721[1], 20500[1], 69990[0]
11000	10060[1], 10061[1], 11100[1], 11719[1], 11720[1], 11721[1], 17110[1], 17250[1], 20600[1], 64400[1], 64402[1], 64405[1], 64408[1], 64410[1], 64412[1], 64413[1], 64415[1], 64417[1], 64418[1], 64420[1], 64421[1], 64425[1], 64430[1], 64435[1], 64445[1], 64450[1], 64475[1], 64479[1], 64483[1], 69990[0], G0127[1]
11010	10060[1], 10120[1], 10121[1], 10160[1], 10180[1], 11055[1], 11100[1], 11450[1], 11451[1], 11462[1], 11463[1], 11470[1], 12001[1], 12002[1], 12004[1], 12005[1], 12006[1], 12007[1], 12011[1], 12013[1], 12014[1], 12015[1], 12016[1], 12020[1], 12021[1], 15000[1], 15851[0], 15852[1], 16000[1], 16010[1], 16015[1], 16020[1], 16025[1], 16030[1], 20000[1], 20005[1], 20100[1], 20101[1], 20102[1], 20200[1], 20205[1], 20206[1], 20220[1], 20225[1], 20240[1], 20245[1], 20250[1], 20251[1], 20520[1], 20525[1], 21501[1], 21550[1], 23030[1], 23930[1], 23931[1], 25031[1], 25065[1], 25066[1], 26010[1], 26011[1], 69990[0], G0168[1]
11011	10060[1], 10120[1], 10121[1], 10160[1], 10180[1], 11010[1], 11055[1], 11100[1], 11450[1], 11451[1], 11462[1], 11463[1], 11470[1], 11471[1], 11720[1], 11721[1], 12001[1], 12002[1], 12004[1], 12005[1], 12006[1], 12007[1], 12011[1], 12013[1], 12014[1], 12015[1], 12016[1], 12020[1], 12021[1], 15000[1], 15781[1], 15782[1], 15783[1], 15851[0], 15852[1], 16000[1], 16010[1], 16015[1], 16020[1], 16025[1], 16030[1], 16035[1], 20000[1], 20005[1], 20101[1], 20102[1], 20200[1], 20205[1], 20206[1], 20220[1], 20225[1], 20240[1], 20245[1], 20250[1], 20251[1], 20520[1], 20525[1], 21501[1], 21550[1], 23030[1], 23930[1], 23931[1], 25028[1], 25031[1], 25065[1], 25066[1], 25101[1], 26010[1], 26011[1], 69990[0], G0168[1]
11012	10060[1], 10120[1], 10121[1], 10160[1], 10180[1], 11010[1], 11011[1], 11055[1], 11100[1], 11450[1], 11451[1], 11462[1], 11463[1], 11470[1], 11471[1], 11720[1], 11721[1], 12001[1], 12002[1], 12004[1], 12005[1], 12006[1], 12007[1], 12011[1], 12013[1], 12014[1], 12015[1], 12016[1], 12017[1], 12018[1], 12020[1], 12021[1], 15000[1], 15780[1], 15781[1], 15782[1], 15783[1], 15851[0], 15852[1], 15950[1], 16000[1], 16010[1], 16015[1], 16020[1], 16025[1], 16030[1], 16035[1], 20000[1], 20005[1], 20101[1], 20102[1], 20103[1], 20200[1], 20205[1], 20206[1], 20220[1], 20225[1], 20240[1], 20245[1], 20250[1], 20251[1], 20520[1], 20525[1], 21501[1], 21502[1], 21510[1], 21550[1], 23030[1], 23930[1], 23931[1], 23935[1], 24000[1], 25020[1], 25028[1], 25031[1], 25035[1], 25040[1], 25065[1], 25066[1], 25101[1], 26010[1], 26011[1], 26990[1], 26991[1], 27000[1], 27001[1], 27003[1], 69990[0], G0168[1]
11040	10060[1], 10061[1], 11100[1], 11719[1], 11720[1], 11721[1], 11900[1], 15851[1], 17250[1], 29075[1], 29105[1], 29125[1], 29260[1], 29405[1], 29425[1], 29445[1], 29515[1], 29540[1],

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CORRECT CODING EDITS FOR MUTUALLY EXCLUSIVE CODES 10000-19999

Col. 1	Col. 2
10060	11401[1], 11402[1], 11403[1], 11404[1], 11406[1], 11421[1], 11422[1], 11423[1], 11424[1], 11426[1], 11441[1], 11442[1], 11443[1], 11444[1], 11446[1], 11450[1], 11451[1], 11462[1], 11463[1], 11470[1], 11471[1], 11600[1], 11601[1], 11602[1], 11603[1], 11604[1], 11606[1], 11620[1], 11621[1], 11622[1], 11623[1], 11624[1], 11626[1], 11640[1], 11641[1], 11642[1], 11643[1], 11644[1], 11646[1], 20000[1], 20005[1], 30000[1]
10061	11406[1], 11424[1], 11426[1], 11440[1], 11444[1], 11446[1], 11450[1], 11451[1], 11463[1], 11470[1], 11471[1], 11604[1], 11606[1], 11623[1], 11624[1], 11626[1], 11643[1], 11644[1], 11646[1], 20005[1]
10160	10061[1], 10140[1]
11000	11010[1], 11011[1], 11012[1], 11056[1], 11057[1], 15000[1], 97601[1]
11010	20150[1], 20661[1], 20662[1], 20663[1], 20692[1], 20693[1], 20802[1], 20805[1], 20808[1], 20816[1], 20822[1], 20824[1], 20827[1], 20838[1], 20900[1], 20902[1], 20910[1], 20912[1], 20920[1], 20922[1], 20924[1], 20926[1], 20955[1], 20956[1], 20957[1], 20962[1], 20969[1], 20970[1], 20972[1], 20973[1], 21010[1], 21015[1], 21025[1], 21026[1], 21029[1], 21030[1], 21034[1], 21041[1], 21044[1], 21045[1], 21050[1], 21060[1], 21070[1], 21076[1], 21077[1], 21079[1], 21080[1], 21081[1], 21082[1], 21083[1], 21084[1], 21085[1], 21086[1], 21087[1], 21088[1], 21110[1], 21120[1], 21121[1], 21122[1], 21123[1], 21125[1], 21127[1], 21137[1], 21138[1], 21139[1], 21141[1], 21142[1], 21143[1], 21145[1], 21146[1], 21147[1], 21150[1], 21151[1], 21154[1], 21155[1], 21159[1], 21160[1], 21172[1], 21175[1], 21179[1], 21180[1], 21181[1], 21182[1], 21183[1], 21184[1], 21188[1], 21193[1], 21194[1], 21195[1], 21196[1], 21198[1], 21199[1], 21206[1], 21208[1], 21209[1], 21210[1], 21215[1], 21230[1], 21235[1], 21240[1], 21242[1], 21243[1]
11010	21244[1], 21245[1], 21246[1], 21247[1], 21248[1], 21249[1], 21255[1], 21256[1], 21260[1], 21261[1], 21263[1], 21267[1], 21268[1], 21270[1], 21275[1], 21280[1], 21556[1], 21557[1], 21600[1], 21610[1], 21615[1], 21616[1], 21620[1], 21627[1], 21630[1], 21632[1], 21700[1], 21705[1], 21720[1], 21725[1], 21740[1], 21750[1], 21925[1], 21930[1], 21935[1], 22100[1], 22101[1], 22102[1], 22110[1], 22112[1], 22114[1], 22210[1], 22212[1], 22214[1], 22216[1], 22220[1], 22222[1], 22224[1], 22226[1], 22548[1], 22554[1], 22556[1], 22558[1], 22585[1], 22590[1], 22595[1], 22600[1], 22610[1], 22612[1], 22614[1], 22630[1], 22632[1], 22800[1], 22802[1], 22804[1], 22808[1], 22810[1], 22812[1], 22830[1], 22840[1], 22842[1], 22843[1], 22844[1], 22845[1], 22846[1], 22847[1], 22848[1], 22849[1], 22850[1], 22851[1], 22852[1], 22855[1], 22900[1], 23020[1], 23035[1], 23040[1], 23044[1], 23076[1], 23077[1], 23100[1], 23101[1], 23105[1], 23106[1], 23120[1], 23125[1], 23130[1], 23140[1], 23145[1], 23146[1], 23150[1], 23155[1], 23170[1]
11010	23172[1], 23180[1], 23182[1], 23184[1], 23190[1], 23195[1], 23200[1], 23210[1], 23220[1], 23221[1], 23222[1], 23331[1], 23332[1], 23395[1], 23397[1], 23400[1], 23405[1], 23406[1], 23410[1], 23412[1], 23415[1], 23420[1], 23430[1], 23440[1], 23450[1], 23455[1], 23460[1], 23462[1], 23465[1], 23466[1], 23470[1], 23472[1], 23480[1], 23485[1], 23490[1], 23491[1], 23800[1], 23802[1], 23900[1], 23920[1], 23921[1], 24066[1], 24076[1], 24077[1], 24100[1], 24101[1], 24102[1], 24110[1], 24115[1], 24116[1], 24120[1], 24125[1], 24126[1], 24130[1], 24134[1], 24136[1], 24138[1], 24140[1], 24145[1], 24147[1], 24149[1], 24150[1], 24151[1], 24152[1], 24153[1], 24155[1], 24160[1], 24164[1], 24201[1], 24301[1], 24305[1], 24310[1], 24320[1], 24330[1], 24331[1], 24340[1], 24341[1], 24342[1], 24350[1], 24351[1], 24352[1], 24354[1], 24356[1], 24360[1], 24361[1], 24362[1], 24363[1], 24365[1], 24366[1], 24400[1], 24410[1], 24420[1], 24430[1], 24435[1], 24470[1], 24495[1], 24498[1], 24800[1], 24802[1], 24900[1], 24920[1], 24925[1]
11010	24930[1], 24931[1], 24935[1], 24940[1], 25076[1], 25077[1], 25085[1], 25105[1], 25107[1], 25112[1], 25116[1], 25119[1], 25120[1], 25125[1], 25126[1], 25130[1], 25135[1], 25136[1], 25145[1], 25150[1],

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In each table, the two codes of an edit pair are ordered so that there is a column 1 code and a column 2 code. If both codes of an edit pair are billed for the same beneficiary, on the same date of service, by the same performing provider, the column 1 code is the one that is eligible for payment. Some code pair edits never allow payment for both codes of the edit pair. However, many code pair edits do permit payment of the column 2 code in addition to the column 1 code under appropriate clinical circumstances. Physicians and providers may use modifiers, appended to the appropriate code, to indicate these circumstances. We will discuss modifiers later in this chapter.

Within the tables, codes are listed by major category of service. The tables used on the previous page are for illustrative purposes only and may not represent the most current CCI Edits Tables.

WHEN ARE THE CCI EDITS UPDATED?

CCI undergoes quarterly updates, generally on January 1, April 1, July 1, and October 1 of each year. The updates may add new edits, delete edits that are no longer necessary, or modify edits. The implementation date for an edit is the date of the first version of CCI in which it appears. If an edit is deleted, its deletion date may be the same as the original implementation date or it may be different.

The Outpatient Code Editor (OCE) is used by fiscal intermediaries for processing hospital outpatient claims under OPPS. While OCE is a separate system from CCI, it uses many of the CCI edits. OCE does not use the CCI edits for anesthesiology, E&M, mental health, and dermabond. The CCI edits used in the OCE are always one version behind those used for physician claims.

MODIFIERS

In this section, CSRs will learn about modifiers and how they impact coding.

WHAT ARE MODIFIERS?

In addition to reporting the five-digit or alphanumeric procedure code, a physician or provider may report modifiers to that code on the same line item. A modifier consists of two numbers, two letters, or one number and one letter, and is used when the physician or provider needs to report extra information about the procedure to Medicare. A modifier allows the reporting physician or provider to show that a service or procedure that was performed was changed by some specific circumstance, but has not changed in its definition or code. The effective use of modifiers makes it unnecessary to use separate procedure codes to describe the modifying circumstance.

Modifiers may be used to indicate the following:

- A service or procedure has both a professional and a technical component.
- A service or procedure was performed by more than one physician or provider or in more than one location.
- Only part of a service was performed.
- An additional service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.

Modifiers may also be used to eliminate the appearance of duplicate billing and to eliminate the appearance of unbundling.

Here are some common reasons why physicians or providers might do this:

1. To show that in this case two procedures on the claim were appropriately performed together even though generally they are not (e.g., repair of two different blood vessels through a single incision).

2. To show that a patient returned for a second operation to treat a complication of a surgery performed earlier the same day.

3. To show that the same procedure was performed several times on different parts of the body (e.g., skin lesion removal).

4. To show that an office visit performed on the same day as a surgical procedure was significant and separately identifiable from the reason for the surgery.

For a list of modifiers, see *CCI Modifiers* in ***Chapter 3***.

There are three modifiers in particular that appear to be a source of confusion for physicians, and as such will be highlighted in this discussion. These modifiers are **–25**, **–59**, and **–91**.

Modifier –25: Significant, Separately Identifiable Evaluation and Management (E/M) Service by the Same Physician on the Same Day of the Procedure or Other Service. Modifier –25 should be appended to an evaluation and management (E/M) code when reported with another procedure on the same day of service. Appending modifier –25 to the E/M code indicates to the carriers or fiscal intermediaries that the physician or provider performed a significant, separately identifiable E/M service above and beyond the other service provided.

Example: An established patient is seen in a physician's office for complaints of cough, runny nose, and sore throat that started five days ago. During examination, the patient also reports of right and left earache. The physician performs an expanded problem focused history and examination with a medical decision-making of low complexity. The physician also examines the patient's ear and performs an earwax removal of the left and right ear. The patient is discharged home on antibiotics with the following diagnoses and procedures: common cold, impacted cerumen, and removal of impacted cerumen.

The above example should be reported with the following CPT codes on the HCFA-1500: ***99213-25*** (covers office visit portion) and ***69210*** (covers removal of impacted cerumen).

NOTE: Modifier –25 should be reported in the following circumstances:

- Same patient, same day encounter;
- Same physician or provider; and
- Patient's condition required a "significant, separately identifiable E/M service above and beyond the usual and pre and post-op care" related with the procedure or service.

Modifier –59: Distinct Procedural Service. Modifier –59 is used to indicate a distinct procedural service. Under certain circumstances, the physician or provider may need to indicate that a procedure/service was distinct or independent from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).

Example: A physician performs a simple repair (2.5 centimeters in size) of a superficial wound to the right arm and also performs a partial thickness skin debridement of another site on the same arm.

The above example should be reported with the following CPT codes on the HCFA-1500: ***12001*** (covers the repair of the superficial wound) and ***11040-59*** (covers skin debridement).

NOTE: Modifier –59 should be reported in the following circumstances:

- When the procedure may represent a:
  1) different session or patient encounter/visit.
  2) different procedure/surgery.
  3) different (body) site or organ (system).
  4) separate incision/excision.
  5) separate lesion.
  6) separate injury (or area of injury in extensive injuries).
- When the procedure or service performed is independent from other services performed on the same day.
- When the procedures or services are not normally reported together.
- When no other modifier best explains the circumstances.

Modifier –91: Repeat Clinical Laboratory Test. Modifier –91 should be appended to laboratory procedure(s) or service(s) to indicate a repeat test or procedure performed on the same day for patient management purposes. This modifier indicates to the carriers or fiscal intermediaries that the physician or provider had to perform a repeat clinical diagnostic laboratory test that was distinct or separate from a lab panel or other lab services performed on the same day, and was performed to obtain medically necessary subsequent reportable test values. This modifier should not be used to report repeat laboratory testing due to laboratory errors, quality control, or confirmation of results.

Example: A patient undergoing chemotherapy for lung carcinoma has a CBC with automated platelet count performed prior to receiving chemotherapy. The patient is noted to have a very low platelet count and receives a platelet transfusion. The

automated platelet count is repeated after the transfusion to assure the platelet count is high enough for the patient to be sent home.

The above example should be reported with the following CPT codes on the HCFA-1500: ***85027*** (covers automated CBC with automated platelet count) and ***85049--91*** (covers repeat automated platelet count).

NOTE: Modifier –91 should be reported in the following circumstances:

- Same patient, same day procedure/service.
- Repeat lab test performed more than once on the same day.

THE ROLE OF THE CSR

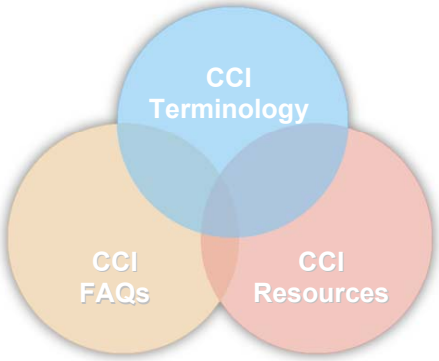
In this section, CSRs will learn their role in CCI.

WHAT IS MY ROLE AS A CSR IN CCI?

CSRs are the primary point of contact for physicians and providers. Physicians and providers expect accurate information that will assist them in completing their claims. As a CSR, it is not your responsibility to provide the correct code or correct CCI modifier for a specific claim. Remember, the ultimate decision on code and modifier selection remains with the physician or provider. You should use the following to guide your interactions with physicians and providers regarding CCI.

CCI Guidelines

1. Understand the general principles behind CCI;
2. Understand CCI terminology;
3. Answer general questions (e.g., provide definition of CCI modifiers); and
4. Direct physicians and providers to the appropriate CCI resources.



Remember, the role of call centers with respect to CCI is to only offer accurate information that will assist the physician or provider in understanding CCI. Here are some suggested steps to take when addressing a CCI question:

Step 1: Confirm that the physician or provider's question relates to a CCI edit and not a carrier specific edit. Carriers implement edits in addition to CCI edits that prevent payment of procedure codes under certain circumstances. Proceed to Step 2 if the question relates to a CCI edit.

Step 2: Determine nature of CCI related inquiry and take action accordingly:

1. A physician or provider thinks that both codes should have been paid based on the clinical facts for the claim under discussion: Inform the physician or provider that the claim should be submitted as an appeal indicating his/her rationale.

2. A physician or provider has noted that CCI has modified or deleted an edit that impacted a claim that had been previously adjudicated by the carrier: The physician or provider should be informed about the process to have his/her claim resubmitted for readjudication. The physician or provider should be told that the claim can be readjudicated only if the date of service is after the original effective date of the edit.

3. A physician or provider thinks edit is incorrect: Offer three alternatives. Emphasize that alternative (a) is the preferred method.

    (a) A physician or provider may contact his/her national medical society and ask for its assistance. The national medical society may be able to explain the rationale for the edit or assist the physician or provider by contacting the National Correct Coding Initiative, at AdminaStar Federal, Inc., requesting review of the edit. This is the preferred approach since CMS assigns high priority to review of edits requested by national societies.

    (b) A physician or provider may write his/her carrier medical director about the rationale for the edit. Since CCI edits are national CMS policy, the carrier medical director cannot change any edit. This alternative may be slower since the carrier medical director may have to contact AdminaStar Federal, Inc., directly to obtain information.

    (c) A physician or provider may write directly to the National Correct Coding Initiative at AdminaStar Federal, Inc., P.O. Box 50469, Indianapolis, Indiana 46250-0469.

For more examples, see ***Chapter 3***:

How to get the manual – related questions start on page 23
CCI terminology – related questions start on page 26
How to use CCI – related questions start on page 28
How to use modifiers – related questions start on page 30
How to appeal claims and CCI edits – related questions start on page 33
The difference between CCI and OCE – related questions start on page 35

CCI RESOURCES

In this Section, CSRs will learn where to find the appropriate resources for CCI.

1. When a physician or provider wants to obtain a copy of the CCI Policy and Edits Manual, you should direct the physician or provider to contact the National Technical Information Service (NTIS) to purchase a copy:

   NTIS Subscriptions Department
   1-800-363-2068 or (703) 605-6060 (8:30 a.m. - 5 p.m., EST, M-F)
   FAX: (703) 605-6880
   5285 Port Royal Road
   Springfield, VA 22161
   E-Mail: **orders@ntis.gov**
   www.ntis.gov/help/subscriptions.asp

2. When a physician or provider wants general information about CCI, you should refer them to one of the following sources for official information:

   a) CCI Frequently Asked Questions (FAQs) online in a "question and answer" format:
   www.cms.hhs.gov/medlearn/ncci.asp

   Also, watch this site for updates on resources. The FAQs are posted in their entirety in ***Chapter 3*** of this Reference Guide for your convenience.

   b) The Medicare Carrier Manual online (provides general information about coding, claims filing, and CCI):
   www.hcfa.gov/pubforms/14_car/3b4620.htm#_1_6

3. When physicians or providers do not agree with an edit, they should send their comments and the reason why they disagree with the edit to:

   The National Correct Coding Initiative
   AdminaStar Federal, Inc.
   PO Box 50469
   Indianapolis, IN 46250-0469
   Fax: (317) 841-4600

4. When physicians or providers want information on the latest OCE edits within the hospital OPPS they should visit the following website:
   www.hcfa.gov/pubforms/transmit/memos/comm_date_dsc.htm

Chapter Notes

CHAPTER 3: CCI QUESTIONS

In this chapter you will learn:

- How to respond to frequently asked physician and provider questions.
- What types of questions CSRs are not expected to answer.

FAQS RELATED TO CCI

This section provides CSRs with a list of FAQs related to CCI with the appropriate response to each question. The FAQs were obtained from the Medicare Learning Network and can be accessed by going to the following website: **www.cms.hhs.gov/medlearn/ncci.asp**.

HOW TO OBTAIN A COPY OF THE CCI POLICY AND EDITS MANUAL

QUESTION #1: How do I obtain the CCI Edits Manual?

ANSWER: The CCI Edits Manual may be obtained by purchasing the manual from the National Technical Information Service (NTIS) website at **www.ntis.gov/help/subscriptions.asp**, or by contacting NTIS at 1-800-363-2068 or 703-605-6060.

QUESTION #2: Before I purchase the manual, I would like to receive more information on it. Can I contact NTIS for more information on the CCI Manual?

ANSWER: Yes, to receive information on the CCI Edits Manual by fax, call 703-605-6880.

QUESTION #3: Why do I have to purchase the CCI edits from NTIS instead of just receiving the information from my Carrier or Fiscal Intermediary?

ANSWER: The volume of edits in each version update is too large to be produced by the Medicare Carriers or Fiscal Intermediaries (FIs) through a Medicare bulletin. Therefore, the CCI manuals must be purchased from NTIS. Please note that CPT-4 codes used in the manual are copyrighted by the American Medical Association. Consequently, NTIS pays the American Medical Association (AMA) licensing fees for their use of the CPT-4 codes in the CCI Edits Manual. The cost of purchasing the CCI edits is determined solely by NTIS.

QUESTION #4: Are the edits in the CCI Edits Manual valid for a whole year?

ANSWER: No, the edits are updated on a quarterly basis. **However, the NCCI is updated annually in October.**

QUESTION #5: There are some software coding programs that already contain the CCI edits. Do I still need to purchase the manual from NTIS?

ANSWER: The official method for physicians to receive the CCI edits is through NTIS at this time. CMS has designated NTIS as the sole distributor of the CCI edits. CMS does not know the accuracy of CCI edits obtained from other sources. Anyone wishing to receive the CCI edits must purchase them through NTIS. It is up to the hospital and to the physician to be aware of the quarterly updates to the CCI Edits Manual.

QUESTION #6: If I have a question about or problem with the quality and format of the NTIS products, whom should I contact?

ANSWER: Contact the NTIS Sales Desk at 1-800-553-6847.

QUESTION #7: Since my practice does not use all the codes in the HCPCS/CPT manuals, can I obtain only the edits that pertain to my specialty?

ANSWER: Yes, the edits are organized by ranges of the comprehensive/column 1 codes into specific chapters (e.g., 00000-09999, 10000-19999, 20000-29999, etc.). You may purchase single chapters that are applicable to your physician's practice.

QUESTION #8: Is there a list of deletions to each version update available or do I have to do a comparison between the previous and the current version updates to determine which ones were actually deleted?

ANSWER: There is not a list of additions, deletions, and edit modifications available for the physicians who order the printed version. However, there is a list of these available for the physicians who have purchased the electronic versions. Please contact NTIS for further information on the electronic version of the CCI edits.

QUESTION #9: How are the CCI edits arranged in the manual?

ANSWER: The edits are arranged by two sets of tables. One table contains the comprehensive/component (correct coding) edits, and the other contains the mutually exclusive edits. Each table is arranged in two columns, as represented below.

Comprehensive/Component Edits	Mutually Exclusive Edits
Column 1/Column 2	Column 1/Column 2

Note that column 2 code in both tables is not payable with the column 1 code unless the edit permits use of a modifier associated with CCI.

QUESTION #10: If I want to determine what codes/procedures are paired with a certain code, how can I find this out?

ANSWER: NTIS provides the printed versions of comprehensive/component (correct coding) and mutually exclusive code edits sorted/sequenced in two ways: by comprehensive/column 1 code and by component/column 2 code. If a single code is found in both sorts, then you should have all the current code combinations active in the CCI with this certain code in either the comprehensive/column 1 or component/column 2 position. The electronic version allows you to search for a code in the database in either position.

QUESTION #11: If I receive a denial for a procedure bundled into another service, and I cannot find this code pair in the comprehensive/component (correct coding) list of edits, where else should I look?

ANSWER: Look in the mutually exclusive code list. The mutually exclusive code edits in the printed version of the CCI Edits Manual are in the same chapter but separate from the comprehensive/component (correct coding) edits.

TERMS AND DEFINITIONS THAT APPLY TO CCI

QUESTION #1: What are CCI edits?

ANSWER: CCI edits are pairs of CPT or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same physician or provider for the same beneficiary on the same date of service. All claims are processed against the CCI tables.

QUESTION #2: What does it mean when a code is considered a "comprehensive code" in CCI?

ANSWER: A "comprehensive code" represents the major procedure or service when reported with another code. The "comprehensive code" represents greater work, effort, and time, as compared to the other code reported.

QUESTION #3: What does it mean when a code is considered a "component code" in CCI?

ANSWER: A "component code" represents the lesser procedure or service when reported with another code. The "component code" is part of a major procedure or service, and is often represented by a lower work relative value unit (RVU) under the Medicare Physician Fee Schedule, as compared to the other code reported.

QUESTION #4: What does it mean when codes are considered "mutually exclusive" of each other?

ANSWER: "Mutually exclusive" codes represent procedures or services that could not reasonably be performed at the same session by the same physician or provider on the same beneficiary.

QUESTION #5: What does "column 1" mean in the comprehensive/component (correct coding) edits table and in the mutually exclusive edits table?

ANSWER: Also known as the "comprehensive code" within the comprehensive/component (correct coding) edits table, this code represents the major procedure or service when reported with another code. When reported with another code, "column 1" generally represents the code with the greater payment of the two codes. However, within the mutually exclusive edits table, "column 1" code generally represents the procedure or service with the lowest work RVU, and is the payable procedure or service when reported with another code.

QUESTION #6: What does "column 2" mean in the comprehensive/component (correct coding) edits table and in the mutually exclusive edits table?

ANSWER: Also known as the "component code" within the comprehensive/component (correct coding) edits table, this code represents the lesser procedure or service when reported with another code. When reported with another code, "column 2" generally represents the code with the lower payment of the two codes. However, within the mutually exclusive edits table, "column 2" represents the procedure or service with the highest work RVU, and is the non-payable procedure or service when reported with another code.

QUESTION #7: Why are there two CCI tables?

ANSWER: To represent the mutually exclusive and comprehensive/component (correct coding) edit tables.

QUESTION #8: What is the mutually exclusive edit table?

ANSWER: The mutually exclusive edit table contains edits consisting of two codes (procedures) which cannot reasonably be performed together based on the code definitions or anatomic considerations. Each edit consists of a column 1 and column 2 code. If the two codes of an edit are billed by the same provider for the same beneficiary for the same date of service without an appropriate modifier, the column 1 code is paid. If clinical circumstances justify appending a CCI associated modifier to the column 2 code of a code pair edit, payment of both codes may be allowed (see section entitled "CCI Modifiers").

QUESTION #9: What is the comprehensive/component edit table?

ANSWER: The correct coding (comprehensive/component) edit table contain two types of code pair edits. One type contains a component code (column 2) which is an integral part of the comprehensive code (column 1). The other types contains code pairs that should not be reported together where one code is assigned as the column 1 comprehensive code and the other code is assigned on the column 2 component code. If the two codes of a code pair edit are billed by the same provider for the same beneficiary for the same date of service without an appropriate modifier, the column 1 (comprehensive) code is paid. If clinical circumstances justify appending a CCI associated modifier to the column 2 code of a code pair edit, payment of both codes may be allowed (see section entitled "CCI Modifiers").

CORRECT CODING PRINCIPLES AND EDITS

QUESTION #1: Where can I find information about the principles utilized to develop edits and examples of edits?

ANSWER: The Correct Coding Policy products include policy narratives that describe the principles utilized to develop edits and also provides examples. This manual is available from the National Technical Information Service (NTIS) at 1-800-363-2068 or 703-605-6060.

QUESTION #2: How often are the CCI edits updated?

ANSWER: The CCI edits are usually updated on a quarterly basis. Note that the CCI edits in the Outpatient Code Editor (OCE) are always one quarter behind.

Jan 2003	8.3 9.0	Hospital Outpatient Prospective Payment System (OPPS) Medicare Physician Fee Schedule (MPFS)
April 2003	9.0 9.1	Hospital Outpatient Prospective Payment System (OPPS) Medicare Physician Fee Schedule (MPFS)
Jul 2003	9.1 9.2	Hospital Outpatient Prospective Payment System (OPPS) Medicare Physician Fee Schedule (MPFS)

QUESTION #3: Specifically, what does the effective date mean for CCI edits?

ANSWER: This date applies to the dates of service on or after a given date. For example, version 9.0 of the CCI edits becomes effective January 01, 2003 for physician services. This means that the new edits to the NCCI for version 9.0 will apply to those claims with dates of service on or after January 1, 2003, however, the NCCI edits continued from previous version updates will be applied to claims with dates of service based on the original effective dates of those edits.

QUESTION #4: Do I need to obtain each version update of the CCI in order to manage our coding practices effectively and efficiently?

ANSWER: Yes, there are a varying number of changes in every update. The volume depends on the number of comments processed, the number of edits reviewed, and/or the number of focused efforts for edit development.

QUESTION #5: Do the edits change that much between quarterly updates?

ANSWER: The number of changes depends on the volume of comments received, modifications processed, and edits reviewed.

QUESTION #6: Why do the mutually exclusive procedures appear to be in the wrong order so that it seems the procedure with the higher payment is generally bundled into the service with the lowest payment?

ANSWER: Although the same action takes place in the Carrier claims processing systems on both the comprehensive/component (correct coding) and the mutually exclusive code edits, which is that the comprehensive/column 1 code is payable and the component/column 2 code is not payable, the mutually exclusive code edits are set up so that the procedure with the lowest work relative value unit is generally listed in the column 1 position as the payable service. This stems from the basic definition of mutually exclusive procedures which states that both these procedures could not reasonably be performed at the same patient encounter. It is expected that one or the other of a mutually exclusive code pair should be reported but not both. Therefore, for the mutually exclusive edits only, to promote correct coding and to deter providers from reporting codes improperly, CMS decided at CCI implementation on January 1, 1996 that the payable code should, in general, be the procedure with the lesser work RVU, which often results in the lowest payment between the two services.

QUESTION #7: If each of the procedures listed in a CCI edit is performed by two different physicians or providers of different specialties in my clinic, will both services be paid?

ANSWER: From a CCI perspective both will be considered for payment because the criteria that must be met for the bundling to occur is that the services are provided for the same beneficiary/patient, on the same date of service, by the same performing provider. However, there may be other national or local carrier/FI policies in place that would not allow both physicians from the same group to be paid in certain situations.

QUESTION #8: Where can I find information about CCI in the Medicare manuals?

ANSWER: Information about CCI can be found in Section 4630 of the Medicare Carrier Manual.

QUESTION #9: What are some of the possible denial messages that may be displayed on the beneficiary's EOMB/MSN?

ANSWER: They are as follows:

a. "Medicare does not pay for this service because it is part of another service that was performed at the same time."
b. "Payment is included in another service received on the same day."

CCI MODIFIERS

QUESTION #1: What modifiers are allowed with the CCI edits?

A1. The following modifiers are allowed with the CCI edits. (12/12/01)

Anatomical Modifiers			Global Surgery Modifier		Other Modifiers
-E1	-F6	-T1	-25	-78	-59
-E2	-F7	-T2	-58	-79	-91
-E3	-F8	-T3			
-E4	-F9	-T4			
-FA	-LC	-T5			
-F1	-LD	-T6			
-F2	-RC	-T7			
-F3	-LT	-T8			
-F4	-RT	-T9			
-F5	-TA				

QUESTION #2: Can these modifiers that are associated with the CCI be used with all the comprehensive/component (correct coding) and mutually exclusive code edits?

ANSWER: No, there are some comprehensive/component (correct coding) and mutually exclusive code edits that CMS does not think would ever warrant the use of any of the modifiers associated with the CCI. These code pairs are assigned a correct

coding modifier indicator of "0" which means that the modifiers associated with the CCI are not allowed. There is no situation in which the physician or provider could justify the payment for both procedures based on separate patient encounters or different anatomic sites.

QUESTION #3: If I determine that one of these modifiers is appropriate and should be used to describe the services I am reporting, to which code do I attach it?

ANSWER: The procedure that is bundled (the component/column 2 code) would require additional information provided by the use of the modifier to explain the circumstance where both services should be paid. Providers are responsible for applying the correct modifiers appropriately to support the codes they report. Inappropriate use of modifiers not justified by the clinical circumstances constitutes fraud.

QUESTION #4: Do I need to append a correct coding modifier to a procedure of a code pair edit if two different physicians performed each of the procedures or if the services were provided on different days?

ANSWER: No, neither different dates of service nor different rendering physicians or providers meet the criteria for bundling.

QUESTION #5: In what instances can I use the modifier –59 to designate a separate, different site?

ANSWER: If none of the anatomical modifiers can be used appropriately to describe the different site, then the modifier –59 can be attached to indicate the separate location.

QUESTION #6: What modifiers can be used to distinguish separate patient encounters on the same day?

ANSWER: The global surgery modifiers are –25, –58, –78, and –79. If none of the previously mentioned modifiers apply, then the modifier –59 can be used to indicate a separate session or patient encounter.

QUESTION #7: How should modifier –25 be reported under the CCI?

ANSWER: Modifier "-25" should be appended to an evaluation and management (E/M) code when reported with another procedure on the same day of service. Appending modifier -25 to the E/M code indicates to the carriers or fiscal intermediaries that as a result of the patient's condition, the physician performed

a significant, separately identifiable E/M service above and beyond the other service provided.

QUESTION #8: How should modifier –59 be reported under the CCI?

ANSWER: Modifier -59 is used to indicate a distinct procedural service. To appropriately report this modifier, append modifier -59 to the column 2 code to indicate that the procedure or service was independent from other services performed on the same day. The addition of this modifier indicates to the carriers or fiscal intermediaries that the procedure or service represents a distinct procedure or service from others billed on the same date of service. In other words, this may represent a different session, different anatomical site or organ system, separate incision/excision, different lesion, or different injury or area of injury (in extensive injuries). When used with a CCI edit, modifier -59 indicates that the procedures are different surgeries when performed at different operative areas or at different patient encounters.

QUESTION #9: How should modifier –91 be reported under CCI?

ANSWER: Modifier –91 should be appended to laboratory procedure(s) or service(s) to indicate a repeat test or procedure on the same day. This modifier indicates to the carriers or fiscal intermediaries that the physician had to perform a repeat clinical diagnostic laboratory test that was distinct or separate from a lab panel or other lab services performed on the same day, and was performed to obtain medically necessary subsequent reportable test values. This modifier should not be used to report repeat laboratory testing due to laboratory errors, quality control, or confirmation of results.

QUESTION #10: Do the Medicare Carriers/Fiscal Intermediaries have different uses or guidelines for the application of the modifiers than the AMA?

ANSWER: In some instances, the use and interpretation of the modifiers is different, even though the description of them is the same.

QUESTION #11: In the manuals purchased from NTIS, what do the superscript numbers "0", "1", and "9" mean?

ANSWER: Each code pair (comprehensive/component [correct coding edits] and mutually exclusive code edits) is assigned a correct coding modifier indicator of either a "0", "1", or "9". The "0" indicator means that no modifiers associated with the CCI are allowed to be used with this code pair; there are no circumstances in which both procedures of the code pair should be paid. The "1" indicator means that the modifiers associated with the CCI are allowed with this code pair when appropriate. The "9" indicator is used on only those code pairs that have been deleted where the deletion

date was retroactive to the effective date. For all practical purposes, physicians and providers can ignore the "9" indicator.

HOW TO OBTAIN ASSISTANCE WITH QUESTIONS RELATED TO CCI EDITS

QUESTION #1: If I think that an edit is incorrect, who addresses my concerns/issues?

ANSWER: AdminaStar Federal (ASF), Inc.(a subcontractor of Reliance Safeguard Solutions) develops and refines the National Correct Coding Initiative, coordinates the receipt of comments, the prioritization of issues, the review and research of previous actions, and the discussion with CMS about the concerns. ASF accepts written comments by fax at (317) 841-4600 or by mail. Their address is indicated below.

National Correct Coding Initiative
AdminaStar Federal, Inc.

P.O. Box 50469

Indianapolis, IN 46250-0469

Attention to: Niles R. Rosen, MD or Linda Dietz, RHIA, CCS, CCS-P

QUESTION #2: What should I send to the NCCI for justification of my proposed modification to the edits?

ANSWER: At a minimum, the comment letter needs to include the HCPCS/CPT codes and descriptors in question and the justification for the proposed change (e.g., clinical medical literature, studies, standards of medical practice, national medical policy, National Specialty Society/Association coding guidelines, AMA's coding instructions in CPT itself or AMA's coding advice as referenced in the CPT Assistant.)

QUESTION #3: How long does it take to review a comment?

ANSWER: We make every effort to respond to almost all comments within six weeks of receipt.

QUESTION #4: Why does it sometimes appear that CMS adds edits to the CCI in one version, and then in the next version changes or deletes those edits?

ANSWER: Changes in the CCI are the result of comments submitted to CMS via AdminaStar Federal, Inc., and CMS's written or telephone correspondence. Sometimes new information, that was not available previously, is provided by a commenter. The ability of CMS to add, delete, and modify edits quarterly enables CCI to be responsive to the physician community.

QUESTION #5: Does anyone have input about these edits before they are implemented?

ANSWER: Edit modifications resulting from comments are often referred to medical societies prior to final disposition of the edit. In addition, the AMA receives a listing of all changes at least one month prior to the quarterly implementation of a new version of the CCI.

Also, each year a large edit package is developed based on changes to CPT/HCPCS Level II manuals (code/instruction, additions, deletions, and revisions). Edits from this package (including any and all edits where claims data shows that both codes in the proposed edit were reported together one or more times) are sent to the CMD Correct Coding Workgroup and to the AMA, which disseminates them to the national (or medical) societies. Comments from CMDs, national societies, and the AMA are considered by CMS before implementation of these edits.

QUESTION #6: Who facilitates the distribution of this yearly package of proposed edits (based on CPT/HCPCS Level II changes) to the National Medical/Surgical Societies for notice and comment?

ANSWER: The American Medical Association coordinates the notice and comment process on behalf of the National Societies by distributing the proposed edits/modifications to the physician and non-physician groups.

QUESTION #7: If I have received a response from RSS which states that CMS has decided not to change the edit about which I complained, is there any other recourse to produce a change?

ANSWER: We frequently encourage commenters to contact the appropriate national organization for guidance when this happens. Commenters may also research the issues further in order to provide new and necessary rationale to support their position.

QUESTION #8: If I have a situation where I think one of the modifiers associated with the CCI should be used, is there someone who can tell me if I am using the modifier properly?

ANSWER: Contact the physician and provider relations department at your local Medicare Carrier/Fiscal Intermediary, present the scenario and ask the question preferably in writing.

QUESTION #9: If I have individual claims to appeal, should I send these to my local Medicare Carrier or Fiscal Intermediary and request a review?

ANSWER: AdminaStar Federal, Inc. has no authority or access to act on individual claims. You must request an appeal from your local Medicare Carrier/Fiscal Intermediary.

QUESTION #10: If I disagree with the payment on a procedure, to whom do I inquire?

ANSWER: Contact the physician and provider relations department at your local Medicare Carrier/Fiscal Intermediary for verification that the payment is correct. There are many national and local coverage and payment policies other than CCI, which may affect payment for a service.

QUESTION #11: If I receive a bundling message that says something is included in a service billed on the same day and I do not find evidence of this edit in the latest version update of CCI, whom should I ask about this denial?

ANSWER: Contact the physician and provider relations department at your local Medicare Carrier/Fiscal Intermediary about other edits that may be in place on a national or local level which have nothing to do with the CCI edits.

QUESTION #12: If I have received a denial on a procedure that was bundled and I notice that the procedure is no longer bundled in the latest version of the CCI edits, can I resubmit or appeal this denial?

ANSWER: Yes, you may resubmit the claim with the denied service. Generally, deletions in CCI edits are retroactive.

CCI and OCE Edits

QUESTION #1: What is the difference between the Outpatient Code Editor (OCE) edits and the CCI edits?

ANSWER: The OCE edits and the CCI edits are two editing systems used to process fiscal intermediary (hospital outpatient) and carrier-related claims, respectively. The

CCI edits are developed based on coding conventions defined in the AMA's CPT Manual, current standards of medical and surgical coding practice, input from specialty societies, and based on analysis of current coding practice. The CCI edits are used for carrier processing of physician and provider services under the Medicare Physician Fee Schedule while the OCE edits are used by intermediaries for processing hospital outpatient services under the Hospital OPPS. The OCE is used in processing OPPS claims. Within the OCE are over 50 OCE edits, which determine whether a specific code is payable under the hospital OPPS. Many of the CCI edits are included in the OCE edits (see edit #19, 20, 39, and 40 below). The OCE edits are used exclusively under the hospital OPPS; they are not used within the Medicare Physician Fee Schedule.

The CCI edits always consist of pairs of HCPCS codes, and are arranged in two tables. One is the comprehensive/component (correct coding) edits table, and the other is known as the mutually exclusive edits table. The OCE edits are arranged in numerical order with descriptions for each edit, as well as a claim disposition for each edit. Examples of OCE edits are listed below. For further information on the latest OCE edits within the hospital OPPS, please visit our website at **http://www.hcfa.gov/pubforms/transmit/memos/comm_date_dsc.htm** to find the latest transmittal (program memorandum) on the OCE.

Edit	Description	Disposition
1	Invalid diagnosis code	Return to Physician (RTP)
2	Diagnosis and age conflict	RTP
3	Diagnosis and sex conflict	RTP
4	Medicare secondary payer alert	Suspend
19	Mutually exclusive procedure that is not allowed by CCI even if appropriate modifier is present	Line Item Rejection
20	Component of a comprehensive procedure that is not allowed by CCI even if appropriate modifier is present	Line Item Rejection
39	Mutually exclusive procedure that would be allowed by CCI if appropriate modifier were present	Line Item Rejection
40	Component of a comprehensive procedure that would be allowed by CCI if appropriate modifier were present	Line Item Rejection

QUESTION #2: Are all the CCI edits incorporated into the OCE?

ANSWER: All CCI edits are incorporated in the OCE with exception of the following: anesthesiology edits, E&M, mental health, and dermabond.

QUESTION #3: How often are the OCE edits updated?

ANSWER: The OCE, including the OCE edits, is updated on a quarterly basis. Note that under the hospital OPPS, CCI edits include in OCE are always one version behind.

QUESTION #4: Who can I contact for questions on issues related to the OCE edits?

ANSWER: For questions on specific OCE edits, please contact the Division of Outpatient Care (DOC) within CMS at 410-786-0378.

QUESTION #5: Specifically, which modifiers are recognized and accepted by the OCE?

ANSWER: All level I and level II modifiers are accepted as valid in the OCE. However, only a subset of valid modifiers are used in OCE editing. Below is a listing of all the modifiers that are used in OCE editing.

Level I (CPT)		Level II (HCPCS)			
-25	-76	-E1	-F5	-RT	-T8
-50	-77	-E2	-F6	-TA	-T9
-58	-78	-E3	-F7	-T1	
-59	-79	-E4	-F8	-T2	
-73	-91	-FA	-F9	-T3	
		-F1	-LC	-T4	
		-F2	-LD	-T5	
		-F3	-LT	-T6	
		-F4	-RC	-T7	

QUESTIONS OUTSIDE OF A CSR'S PURVIEW

CSRs are often asked difficult questions that are not within their purview. Most often these questions will be regarding giving the correct code. The following are two ways a physician or provider might phrase a question that suggests that a CSR should provide the correct code.

QUESTION #1: Can you give me the correct code, or confirm if this is the correct code, to use for this claim?

ANSWER: I am unable to answer coding questions related to a specific claim. Specific beneficiary circumstances, time spent with the patient, and other factors can influence which code is appropriate to describe your service or procedure. Let me help you get information about coding and definitions associated with the procedure you are asking about.

QUESTION #2: Can you tell me the correct CCI modifier, or confirm if this is the correct CCI modifier, for this claim?

ANSWER: I am unable to answer specific coding or CCI modifier questions for your claim, but I can help explain CCI modifier definitions.

APPENDICES

In these appendices you will find:

- Appendix A: Provider outreach and education
- Appendix B: A self-assessment
- Appendix C: Answers to self-assessment
- Appendix D: A glossary of terms
- Appendix E: Quick hits
- Appendix F: A course evaluation form

APPENDIX A: PROVIDER COMMUNICATIONS GROUP

WHAT IS PCG?

The Provider Communications Group (PCG) is the organization within CMS that develops and disseminates education and training information specifically for physicians, providers, and suppliers.

PCG's mission is to use education, outreach, and customer service to build positive business-to-business relationships with physicians, providers, and suppliers. PCG's job is to ensure that health care professionals receive timely, accurate, and relevant Medicare coverage information to better serve all Medicare beneficiaries.

WHAT IS MLN?

The Medicare Learning Network (MLN) is the conduit for Medicare training and education programs specifically for physicians, providers, and suppliers. By hosting the MLN, CMS seeks to help physicians, providers, and suppliers better understand and navigate through Medicare's rules and requirements. When health care professionals find it easier to work with Medicare, they can focus their primary attention on caring for their patients.

For a complete list of available products and services see:

www.cms.hhs.gov/medlearn/products.asp

APPENDIX B: SELF-ASSESSMENT

This is a self-assessment that will help you gauge your understanding of the material discussed in this reference guide. The answers are provided on the next page.

1) HCPCS Level I codes:
   a) Were developed and copyrighted by AMA
   b) Are only used by Medicare physicians
   c) Are being eliminated as a result of HIPAA
   d) Are used by physicians and providers to submit claims for services
   e) Both a and d

2) Comprehensive codes:
   a) Denote complex procedures
   b) Describe a combination of services
   c) Will be eliminated because of HIPAA
   d) Both a and b

3) Mutually Exclusive codes:
   a) Are billed together
   b) Represent procedures that could not reasonably be performed together
   c) Are never billed together
   d) None of the above

4) CCI was designed to:
   a) Promote correct coding by hospitals
   b) Ensure appropriate payment for Medicare physician and provider services
   c) Both a and b
   d) None of the above

5) True or False: Physicians and providers can never bill more than one procedure per claim

6) True or False: A CSR cannot give codes or present code specific information.

APPENDIX C: ANSWERS TO SELF-ASSESSMENT

1) **HCPCS Level I codes:**
e) Both a and d. HCPCS were developed and copyrighted by AMA and are used by physicians to submit claims for services.
Refer to Chapter 1 for details.

2) **Comprehensive codes:**
d) Both a and b. Comprehensive codes denote complex procedures and describe a combination of services.
Refer to Chapter 3 for details.

3) **Mutually Exclusive codes:**
b) Represent procedures that could not reasonably be performed together.
Refer to Chapter 3 for details.

4) **CCI was designed to:**
b) Ensure standardized procedure coding and appropriate payment for Medicare physician and provider services.
Refer to Chapter 2 for details.

5) **Physicians and providers can never bill more than one procedure per claim.**
The correct answer is **False.** When appropriate, physicians and providers can bill each procedure as a separate line item.
Refer to Chapter 1 for details.

6) **A CSR cannot give codes or present code specific information.**
The correct answer is **True**. Physicians and providers are responsible for coding their own claims.
Refer to Chapter 2 for details.

APPENDIX D: GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The agency formerly known as the Health Care Financing Administration (HCFA).
Column 1 Code	Also known as the "comprehensive code" within the comprehensive/component (correct coding) edits table, this code represents the major procedure or service when reported with another code. When reported with another code, "column 1" generally represents the code with the greater payment of the two codes. However, within the mutually exclusive edits table, "column 1" code generally represents the procedure or service with the lowest work RVU, and is the payable procedure or service when reported with another code.
Column 2 Code	Also known as the "component code" within the comprehensive/component (correct coding) edits table, this code represents the lesser procedure or service when reported with another code. When reported with another code, "column 2" generally represents the code with the lower payment of the two codes. However, within the mutually exclusive edits table, "column 2" represents the procedure or service with the highest work RVU, and is the non-payable procedure or service when reported with another code.
Component Code	Represents the lesser procedure or service when reported with another code. The "component code" is part of a major procedure or service, and is often represented by a lower work relative value unit (RVU) under the Medicare Physician Fee Schedule as compared to the other code reported.
Comprehensive Code	Represents the major procedure or service when reported with another code. The "comprehensive code" represents greater work, effort, and time as compared to the other code reported.
Correct Coding Initiative (CCI)	A CMS developed initiative that promotes correct coding by physicians and providers and ensures that it made appropriate payments for physician and provider services.

Term	Definition
Modifier	Consists of two numbers, two letters, or one number and one letter and is used when the physician or provider needs to report extra information about the procedure to Medicare.
Modifier-25	Should be appended to an evaluation and management (E/M) code when reported with another procedure on the same day of service. Appending modifier "25" to the E/M code indicates to the carriers or fiscal intermediaries that as a result of the patient's condition, the physician or provider performed a significant, separately identifiable E/M service above and beyond the other service provided.
Modifier-59	Used to indicate a distinct procedural service. To appropriately report this modifier, append modifier "59" to the code that represents the lesser or secondary procedure(s) or service(s) to indicate that the procedure or service was independent from other services performed on the same day. The addition of this modifier indicates to the carriers or fiscal intermediaries that the procedure or service represents a distinct procedure or service from others billed on the same date of service.
Modifier-91	Should be appended to laboratory procedure(s) or service(s) to indicate a repeat test or procedure on the same day. This modifier indicates to the carriers or fiscal intermediaries that the physician or provider had to perform a repeat clinical diagnostic laboratory test that was distinct or separate from a lab panel or other lab services performed on the same day, and was performed to obtain medically necessary subsequent reportable test values. This modifier should not be used to report repeat laboratory testing due to laboratory errors, quality control, or confirmation of results.
Mutually Exclusive Codes	Represent procedures or services that could not reasonably be performed at the same session by the same physician or provider on the same beneficiary.

APPENDIX E: QUICK HINTS

These quick hints were designed to bring attention to key elements that CSRs should always keep in mind when servicing physicians and providers regarding CCI.

1) CCI edits apply to claims that contain more than one procedure.

2) CCI requires physicians and providers to report the comprehensive procedure code instead of reporting multiple codes that describe parts of the comprehensive procedure.

3) CCI prevents physicians and providers from reporting two procedures that could not have reasonably been performed together.

4) CSRs may not provide codes and modifiers to physicians and providers.

5) The role of call centers with respect to CCI is to only offer accurate information that will assist the physician and providers in understanding CCI.

6) The CCI Edits Manual can be purchased from the National Technical Information Service (NTIS) website at **www.ntis.gov/help/subscriptions.asp** or by contacting NTIS at 1-800-363-2068 or 703-605-6060.

7) The OCE edits and the CCI edits are two editing systems used to process fiscal intermediary (hospital outpatient) and carrier-related claims, respectively.

8) CCI edits are divided into two separate tables for comprehensive codes and mutually exclusive codes.

9) AdminaStar Federal, Inc., is the Medicare contractor responsible for overseeing CCI.

10) It is preferred that physicians and providers contact their medical society if they want to recommend changes to CCI.

Chapter Notes

APPENDIX F: COURSE EVALUATION FORM

Understanding CCI Course Evaluation

Date:_____ Name: (optional) _____ Location:_____

Your feedback will enable us to continue to provide the highest quality training possible. The information you provide will be used to refine future training sessions. Thank You!

Rating System

Strongly Disagree (1) **Disagree (2)** **Neither (3)** **Agree (4)** **Strongly Agree (5)**

Assess the following statements by circling your choice on the scale provided.

I. Course Content and Design

A.	The objectives were clearly identified	1	2	3	4	5
B.	The reference guide content was clearly organized	1	2	3	4	5
C.	The flow of the content made sense	1	2	3	4	5

II. Training Materials

A.	Participant materials were useful during the course	1	2	3	4	5
B.	Participant materials were well written and accurate	1	2	3	4	5
C.	Participant materials will be useful references for me when I return to the workplace	1	2	3	4	5

III. Overall Reference Guide

A.	Was the self-assessment fair and useful in helping you recall key elements?	1	2	3	4	5
B.	The overall reference guide was satisfactory and met my expectations	1	2	3	4	5

Please rank the following sections of chapter in order from most to least useful in helping you to understand the central concepts of this class. 1 represents the most useful, 4 represents the least helpful.

	Ranking
Chapter 1 - Coding	_____
Chapter 2 - CCI Basics	_____
Chapter 3 - CCI Questions	_____
Appendices	_____
▪ A – Provider Outreach and Education	_____
▪ B – Self Assessment	_____
▪ C – Answers to Self Assessment	_____
▪ D – Glossary	_____
▪ E – Quick Hits	_____
▪ F – Course Evaluation	_____

What changes would you recommend to this training program?